Diana Dizik, DDS

General and Cosmetic Dentistry

720 N El Camino Real
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Phone: 650.348.5424
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Patient Name:_____ Date of Birth:_____

Patient Responsibilities

Dental Benefit Plans

Your dental benefit is a contract between you and your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you and your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage. Our office will process insurance claims as a courtesy to you. We do everything we can to have an accurate estimate of the patient portion for your treatment. Please note that any estimates given are estimates only and are not a guarantee of payment as some restrictions set forth by your insurance carrier may apply.

Payment Policy

Payment for dental services is due on the day dental services are rendered unless previous financial arrangements have been made.

Appointment Scheduling and Cancellation Policy

We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it affects the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. **With less than 48-hour notice, a fee of $75 per hour, based on the length of the scheduled appointment, will apply and a deposit to reserve the appointment time again, may be required.** To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is 15 minutes late arriving to our practice. **To reschedule an appointment due to late arrival, a fee of $75 will apply and a deposit to reserve the appointment time again, may be required.**

Patient Authorizations

I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. _____ (initial)

I have read the above and agree to the financial and scheduling terms. _____(initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. _____(initial)

Patient Communication

Email

At this time, our practice utilizes unencrypted electronic communication to communicate with our patients regarding their appointments and treatment. We also use unencrypted electronic communication to disclose patients' health information to another dentist or other health care providers providing treatment that we do not provide (For example forwarding xrays and any pertinent information to an oral surgeon or a root canal specialist as the need arises and as they become involved in the patient's care). **Unencrypted email is not a secure form of communication**. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive unsecured email from us regarding your treatment. **We will always use the minimum necessary amount of protected health information in any communication.**

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_____(initial) **Yes**, I do consent and accept the risk in receiving all information, including appointment reminders and treatment information, via unencrypted email. I also consent to the practice's communication via unencrypted email with other health care providers as it relates to my treatment. I understand I can withdraw my consent at any time.
My email address is_____.

_____(initial) **No**, I do not consent to receiving any information via email, including appointment reminders and treatment information. I also do not consent to the practice's communication via email with other health care providers as it relates to my treatment. I understand that I can change my mind and provide consent later.

Voice Messages

I understand brief messages from the dental practice may be left on my home answering machine or with anyone who answers the telephone at my home unless I have provided the practice with alternate instructions for communication. _____ (initial)

Cellphone

I consent to the dental practice using my cellphone number to call regarding appointments, treatment, insurance and my account. I understand that I can withdraw my consent at any time. _____(initial)
My cellphone number is (include area code) _____ .

Patient Acknowledgements

HIPAA Notice of Privacy Practices

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. _____ (initial)

Dental Materials Fact

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _____(initial)